Adult Community Mental Health Centre Service Specification

Service Specification Information

Service Specification number:

Classification:

Clinical

Supersedes:

440-CRHTT Service Specification

Version number:

V1

Date of Equality Impact Assessment:

03/10/2023

Approval Information

Approved by:
Mental Health and Learning Disabilities Written Control Documentation Group

Date of approval:

Enter approval date

Date made active:

Enter date made active (completion by Service Specification team)

Review date:

Click or tap to enter a date.

Summary of document:

The aim of the document is to provide the framework for Community Mental Health Centres (CMHC). The teams provide a flexible, responsive, and integrated service to mental health service users and their carers in the most appropriate setting. The CMHC will provide an assessment service to people with a range of mental health problems and assessment and treatment for individuals who are Relevant Patients under the Mental Health (Wales) Measure 2010 (MHM).

Scope:
The Community Mental Health Centre Service Specification is primarily intended for staff working within the service. This includes a range of professionals, Nurses, Healthcare Support Workers, Doctors, Occupational Therapists, Occupational Therapy Technicians, Psychologists, Pharmacists, Social Workers, Administration Staff and Peer Support Workers. It will function as an instructional guide to ensure service delivery and operations are carried out to an agreed set of processes and standards.

To be read in conjunction with:

170- Lone Worker Policy

268- Medicines Policy

868- All Wales Safeguarding Procedure

1122- Mental Health Single Point of Contact Service Specification

389- Expenses Policy

395- Section 136 – 1983 Mentally Disordered Persons Found in Public Places Inter-Agency Procedure

731- Leave of Absence Policy

688- Section 117 - After Care Policy

370- Discharge and Transfer of Care Adults Policy

465- All Wales Social-Media Policy

195 Clinical Record Keeping Policy

320- Acceptable use of Information and Communication Technology Policy

Welsh Health Circular- Information Disclosure for the protection of patients and others

Occupational Therapy Community Pathway

Patient information:
Include links to Patient Information Library

Owning group:

Mental Health & Learning Disabilities Written Control Documentation Group

Date signed off by owning group

Executive Director job title:

Andrew Carruthers, Executive Director of Operations

Reviews and updates:

V1 Initial Draft Service Specification Development.

Keywords
Community Mental Health Centre, Community Mental Health Team, Community Mental Health Services, Crisis Resolution and Home Treatment Team, Assessment and Home Treatment, Secondary Care.

Glossary of terms

A&E	Accident and Emergency
AMAU	Acute Medical Admissions Unit
AMHP	Approved Mental Health Professional
CDAT	Community Drug and Alcohol Team
CDU	Clinical Decisions Unit
CMHC	Community Mental Health Centre
CMHS	Community Mental Health Services
CMHT	Community Mental Health Team
CPN	Community Psychiatric Nurse
CRHT	Crisis Resolution and Home Treatment
CTP	Care and Treatment Plan
DDAS	Dyfed Drug and Alcohol Service
DGH	District General Hospital
IPTS	Integrated Psychological Therapy Service
MAPPA	Multi-Agency Public Protection Arrangements
MDT	Multidisciplinary Team
MH&LD	Mental Health and Learning Disability
MHLS	Mental Health Liaison Service
MIU	Minor Injuries Unit
NICE Guidelines	National Institute for Health and Care Excellence Guidelines
OPA	Outpatient Appointment
OTs	Occupational Therapists
PADR	Performance Appraisal Development Review
PocHi	Point of Care Haematology
SCAMHS	Specialist Child & Adolescent Mental Health Service
SCT	Secondary Care Team
SPOC	Single Point of Contact
SSWA	Social Services Wellbeing Act
WCP	Welsh Clinical Portal
WPAS	Welsh Patient Administration System
WWAMH	West Wales Action for Mental Health

Contents

Introduction and Principles

Hywel Dda University Health Board together with service users, staff, carers, and key stakeholders co-designed the model for adult mental health services, where people are supported to recover from mental health difficulties and live full and meaningful lives through services that inspire hope, confidence and understanding.

The delivery of enhanced community mental health provision reduces the reliance on in-patient services. The recovery model defines the philosophy of the service. This means that the individual is supported to 'recover' to work towards aspirations and goals that give value and meaning to their lives.

The Community Mental Health Centre (CMHC) model provides assessment and treatment via the Crisis Resolution and Home Treatment Team (CRHT), assessment and Care Co-ordination for 'Relevant Patients' via the Community Mental Health Team (CMHT) as well as rotation of CRHT staff into the Liaison Service which facilitates 24 hours a day, seven days a week operation.

The service has a clear identity and ethos that ensures the needs of patients are managed appropriately, based on Hywel Dda University Health Board values and principles:

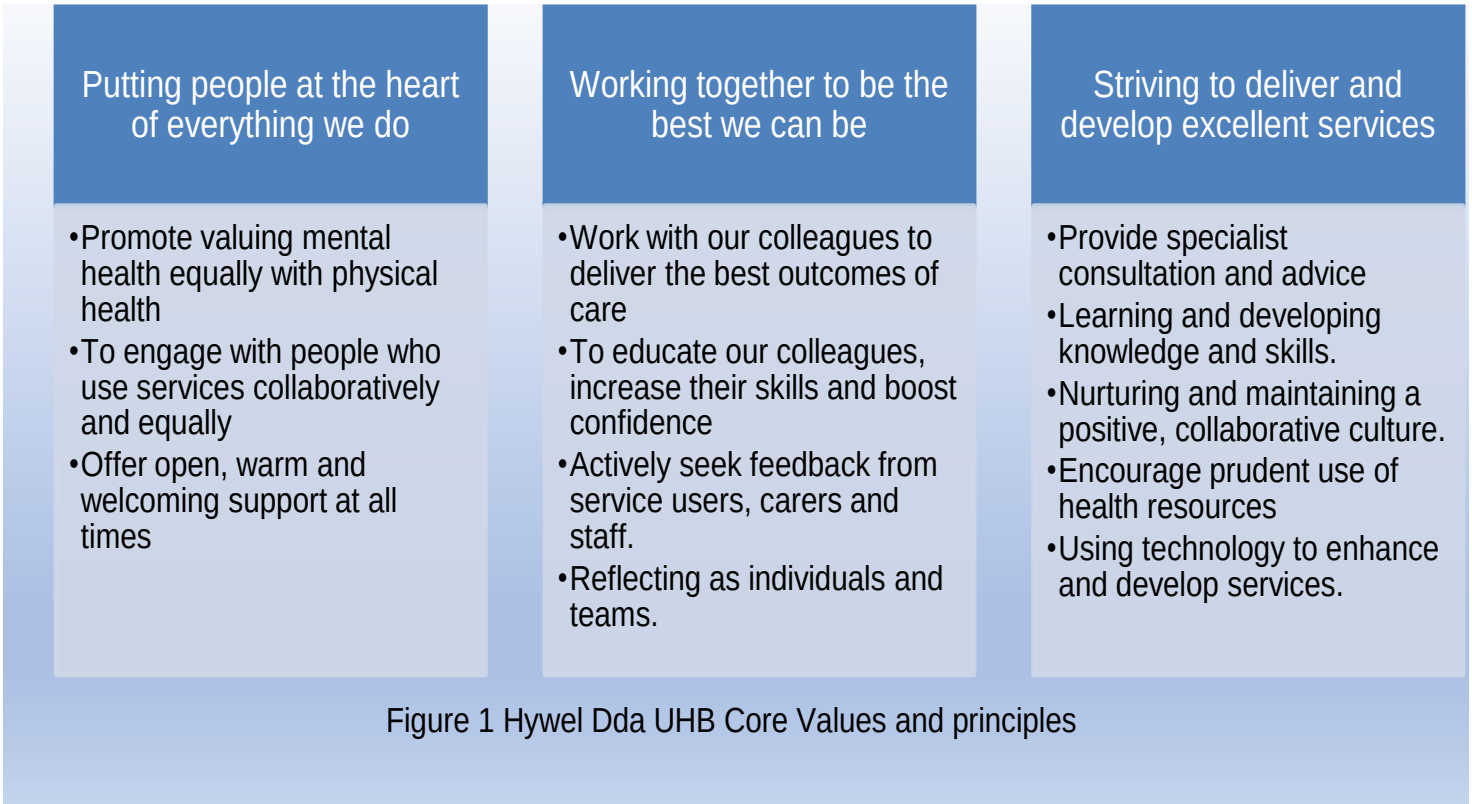


Figure 1 Hywel Dda UHB Core Values and principles

Service Objectives

In conjunction with internal and external services provide assessment and treatment of mental health needs and where appropriate provide care co-ordination working within recovery model principles.

To meet the needs of service users who are:

- Experiencing mental health distress or mental illness.
- Require risk assessments and management for individuals at risk to themselves, or others.
- Require positive risk management in relation to mental health needs through effective Multidisciplinary Team (MDT) working and collaboration with service user and family/carers and other involved agencies.
- Require support, advice and education for their family members or carers.
- Eligible under secondary care according to the Wales Mental Health Measure Part 2 and facilitate self-referral via part 3.

And who:

- Reside within Hywel Dda's geographical footprint.
- Would meet the criteria for Adult Mental Health services regardless of an upper age limit.
- Are over the age 18. For individuals aged 16-18yrs there will be liaison with the Specialist Child & Adolescent Mental Health Service (SCAMHS) in hours or out of hours.

Referrals for patients over the age of 70 with first presentation or who meet the frailty eligibility criteria will be directed to Older Adult Mental Health Services.

In order to:

- Provide timely assessment and access to mental health services, and/or provides information, advice, or support to access other relevant services.
- Provide a service which works closely with other mental health services, social services, primary care, the third sector and Police.
- Act as 'screening gatekeeper' to acute inpatient beds and facilitate early discharge when indicated that home treatment is the least restrictive option.
- Provide a service which is an alternative to hospital admission through the provision of home assessment and/or treatment.
- Provide a mental health assessment service, seven days a week.
- Provide an alternative to acute in-patient care through provision of home treatment for individuals identified as a 'Relevant Patient' under the MH Measure usually for no more than six weeks. There should be a clear rationale if continued involvement is required beyond this. This should be identified as part of an individual's Care & Treatment Plan (CTP).

The CMHC is required to meet Welsh Government Gatekeeping targets:

- Target 1 – 95% of Admissions 9am to 9pm to be gatekept.
- Target 2 – 100% of non-gatekept admissions reviewed in 24hours.

Across Hywel Dda all admissions are gate kept by the Duty Clinical Co-ordinator and reviewed for early discharge within twenty-four hours.

Mental Health Measure:

- Part 2 Target (Care Coordination and Care and Treatment Plans) 90% of patients who are subject to Part 2 have a valid Care and Treatment Plan.

- Part 3 Target (Assessments of former Secondary Mental Health Service Users) 100% of assessment reports sent within 10 working days.

Part 3 of the Measure requires that: Local Health Boards and Local Authorities have arrangements in place to receive self-referrals from relevant patients discharged within the previous 3 years and to undertake assessments within 28 days. The regulation made under Part 3 requires that a copy of the report be provided to the individual who was assessed no later than 10 working days after the conclusion of the assessment.

These guiding principles are set out in the Measure:

- **Patients and their carers should be involved in the planning, development and delivery of care and treatment to the fullest possible extent** –professionals seek to involve a person as fully as possible in their care and treatment in a sensitive way, and one which promotes their confidence and recovery.

- **Equality, dignity, and diversity** – so that professionals have due regard to a person's needs arising from their race, gender, religion, sexuality age or disability when delivering a service.

- **Clear communication in terms of language and culture is essential to ensure patients and their carers are truly involved and receive the best possible care and treatment** – there is always an understanding that poor communication too often leads to inappropriate care and treatment, and that good communication is likely to lead to better outcomes. This principle also states that all possible steps should be taken to ensure that bilingual (Welsh and English) services are available.

- **Care and treatment should be comprehensive holistic, and person-focussed** – so that professionals are sensitive to the full range of a person's needs and that they plan care treatment and support across whatever needs will help a person's recovery.

- **Care and treatment planning should be proportionate to need and risk** – there is a recognition that, whilst on the one hand, some people with complex needs may need detailed care plans, on the other some people may need un-complicated help that will still significantly improve their situations.

- **Care and treatment should be integrated and coordinated** – when offering care and treatment, professionals recognise the range of services that may benefit a person, whether in the statutory or voluntary sectors, whether specialist mental health services or more general services, and actively work together with other services to coordinate service delivery.

Aim of Service

The provision of services is centred on the needs of individual users, their families, and carers with the individual rights to dignity and choice being respected at all times.

CMHC's are located within the centre of communities and provide strong links to other services, both statutory and voluntary. The Centre comprises of two teams (CRHT and CMHT) which individuals can move seamlessly through, without the requirement for referral or repeated assessment.

The CMHC will uphold guiding principles in respect to recovery, that it is possible for each individual to achieve goals that enable the individual to live a fulfilling life, despite serious mental illness and it is possible for someone to regain in time, a meaningful life.

The service will offer an alternative to hospital admission for individuals presenting in an acute episode of mental health distress and instead provide assessment and treatment in their home environment.

The CMHC is composed of a multidisciplinary skill mix of Medical Staff, Psychiatrists, Psychologists, Pharmacists, Nurses, Healthcare Support Workers, Occupational Therapists, Occupational Therapy Technicians, Social Workers, and Peer Support Workers. All qualified staff members will be registered with the appropriate regulatory body.

Mental Health recovery should be an equitable partnership between the Mental Health professional and the individual, which recognises both the expertise and resources of the Mental Health professional and equally recognises the potential within each individual to play a significant part in their own journeys towards Mental Health recovery.

The Team has a clear identity and ethos to ensure that the needs of individuals presenting in an acute episode of mental health distress are managed appropriately based on the following principles:

- Working in partnership
- Practising ethically
- Identifying peoples' strengths and needs
- Promoting safety and positive risk taking
- Respecting diversity
- Promoting recovery
- Providing person-centred care
- Personal development and learning

- **Role of Consultant Psychiatrists and Medical Staff:**

  - Assessment, diagnosis, provide treatment recommendation and medication management.
  - Exercise responsibilities of a Responsible Clinician in accordance with the Mental Health Act.
  - Provide teaching and support to multidisciplinary team (MDT) and Junior Doctors.

- **Role of the Senior Nurse:**
  - To provide clinical, professional, and operational leadership, guidance, and direction to the Team leaders, Senior Practitioner, and the MDT.
  - Ensure the delivery of a safe consistent and effective mental health service to the communities represented by the team.
  - Contribute to service developments to ensure that evidence-based care is delivered efficiently.
  - Provide assurance that services are being delivered as expected.
  - Resolving professional differences which may occur.
  - Ensures DATIX and feedback are managed within the time scales, ensuring any learning and improvements are implemented and shared within the service.

- **Role of the Team Leader:**

  - To act as a role model to the team, support staff through clinical leadership and guidance.
  - Promoting staff well-being and fostering a positive team culture
  - Ensure appropriate tailored care plans are in place using a recovery focus, monitoring progress though caseload and management supervision.
  - Accountable for team performance and the quality of the service delivered.
  - Ensure efficient management of resources and budgets.
  - Working collaboratively with multiple agencies.
  - Manage incidents, complaints, and compliments within the time scales, ensuring any learning and improvements are implemented and shared within the team and wider service.

- **Role of the Nurse/ Mental Health Practitioner:**

  - Undertake comprehensive Mental Health and Risk Assessments in a timely manner.
  - Focus on rehabilitation and recovery for Relevant Patients through provision of evidence-based interventions in accordance with NICE Guidelines.
  - Deliver a range of interventions to promote recovery and prevent mental illness re-occurring, through social interventions, medication, psychological techniques, and relapse prevention work.

- **Role of Occupational Therapists:**

Occupational Therapists (OTs) deliver specialist Occupational Therapy approaches and interventions. OTs support individuals to participate in meaningful activities and promote improved function across personal and domestic activities of daily living, social, leisure and work activities and education or training activities. Occupational Therapists work alongside Occupational Therapy support workers and Peer Support Workers to deliver recovery focused interventions. Uniquely, Occupational Therapists are dual trained across mental health and physical settings and can offer a holistic assessment of need, including provision of aids and equipment, where required.

Occupational Therapists offer:

- A variety of specialist observational and interview-based assessments to identify changes in occupational functioning.
- Home visit environmental assessments to determine suitability of living accommodation, including activity analysis, and providing aids/adaptations.
- Person centred goal planning.
- Specialist 1:1 and group interventions including recovery through activity, personal and domestic activities of daily living skills building, re-engagement in meaningful occupations and graded return to normal activities.
- Recovery focused interventions including support for individuals wanting to return to work, education, or training.
- Strong links with third sector and community activity providers to support service users to re-engage with local activities and build social networks.
- Specialised risk assessments around occupational engagement and participation.

Occupational Therapists may pick up referrals during MDTs but will also accept inter team referrals where occupational needs are identified. Once a referral is accepted the OT will follow the OT pathway Occupational Therapy Community Pathway (*opens in new window*).

- **Role of Social Workers:**

  - To deliver statutory mental health responsibilities in respect of the Mental Health Act. Professional skills include working in partnership with individuals and their cares to promote self-management with a community focus within the Social Services Wellbeing Act (SSWBA).

  - Approved Mental Health Professionals undertake assessment and care co-ordination in respect of the Mental Health Act.

- **Role of Psychologists:**

For people with complex mental health issues and comorbidity, Practitioner Psychologists in the CMHC provide comprehensive psychological assessments with a view to developing formulations that guide interventions/treatment recommendations, the management of risk and inform care and treatment plans. Where standardised/structured intervention has proven to be ineffective formulation-driven and evidence-based interventions may be offered.

In addition to specialist assessments (including cognitive assessments) and the delivery of interventions, Practitioner Psychologists contribute to strategic developments and provide highly specialist consultation, training, supervision, research, and evaluation and has direct links to the Doctoral Level Training Programmes.

Psychologists are integral to the CMHC, disseminating knowledge, contributing to the development of the services, and supporting staff by facilitating reflective/team formulation sessions and support following serious incidents.

Under close supervision Assistant Psychologists support the delivery of the service. This includes the delivery of low-level psychologically informed interventions.

For those embedded within the CRHTT this includes the delivery of low-level psychologically informed interventions.

- **Role of Pharmacists:**

There is a dedicated Mental Health and Learning Disability (MH&LD) Pharmacy Department based in Glangwili Hospital. This team comprises of a Specialist Mental Health Pharmacist, Technicians, and Support Workers. They deliver a service throughout the Health Board. The Specialist Mental Health Pharmacist will provide a service to the CMHC/CMHT which includes:

  - Attendance at Clozapine clinics in the CMHC/CMHT (that hold Clozapine clinics), together with at least one member of staff from the team who is able to run the PocHi machine. The Pharmacist will speak to each patient regarding their medication and offer help and advice around any side effects they may have. They will then give the patient their Clozapine medication once a GREEN result is obtained from the PocHi machine. They will also advise on what to do if an AMBER or RED alert is received in clinic.

- Participation in the referral screening meeting where possible, to provide any medication recommendations at the point of referral.

- Attendance at the weekly MDT within the CMHC/CMHT, either in person or via Microsoft Teams. To advise on any medication queries the team have with current patients or any recommendations to be made following a screening by the team.

- To provide a point of contact to all CMHC/CMHT with regards to any medication queries.

- Pharmacists can be requested to attend OPA or CTP reviews by the Care Coordinator when required with a medic, either in person or via Microsoft Teams if needed for medication advice.

- To offer advice to GPs with regards to medication, in particular psychotropic medication. This can be done via the telephone: 01267 227367 or email MentalHealthPharmacy.Account@wales.nhs.uk

- The CMHC/CMHT can also liaise with the Mental Health Pharmacy Team for any medication management issues outside the weekly CMHC/CMHT meetings via the above contact telephone number or email address.

- To ensure that the CMMHC/CMHT have adequate supply of depot medications for their depot clinics and to ensure that all prescriptions have a clinical check and are then sent to the Homecare Team in a timely manner for delivery to the CMHC/CMHT.

- **Role of the Health Care Support Worker**

Health Care Support workers work under direct supervision of a Mental Health Practitioner to support rehabilitation and recovery.

- Prepare and provide agreed individual development and therapeutic activities.
- Aiding assessments and treatment of individuals under Care and Treatment, providing valuable feedback to mental Health Practitioners.
- To participate in effective liaison between the MDT and other agencies.

- **Role of the Peer Support worker:**

- The peer support worker is an equal to the individual, with a relationship based on mutuality and reciprocity. They use their shared experience connection to give the individual a sense of hope and possibility. They walk the journey alongside the individual for a while.

- Their objectives are to work with the individual's own goals and aspirations, to empower them to become self-directed learners, developing their own self-management strategies, making their own choices, and developing connections in the community.

- They aspire to be strengths based, person centred, non-directive, progressive, inclusive, safe, recovery and community focused.

Scope

This procedure applies to CMHC's and CMHT's within the Hywel Dda University Health Board Mental Health and Learning Disabilities Directorate who provide a service to the population of the three counties of Carmarthenshire, Ceredigion, and Pembrokeshire.

There are four Community Mental Health Centres:

Carmarthen CMHC **Wellfield Resource Centre** 22 Wellfield Road Carmarthen SA311DS CMHT.Wellfield.HDD@wales.nhs.uk Tel No: 01267236017 **Hafan Hedd CMHT** Adpar Newcastle Emlyn Ceredigion SA38 9NS hafan.hedd.hdd@wales.nhs.uk Tel No: 01559 364160	**Pembrokeshire CMHC** **Bro Cerwyn** Fishguard Road Haverfordwest Pembrokeshire SA61 2PR CMHT.Brocerwyn.HDD@wales.nhs.uk Tel No: 01437 773157 **Havenway CMHT** South Pembrokeshire Hospital Fort Road Pembroke Dock Pembrokeshire SA72 6SY CMHT.Havenway.HDD1@wales.nhs.uk Tel No: 01437 774042
Llanelli CMHC **Brynmair Clinic** 11 Goring Road Llanelli Carmarthenshire SA15 3HF CMHT.Brynmair.HDD@wales.nhs.uk Tel No: 01554 772768 **Swn Y Gwynt CMHT** Tir-Y- Dail Lane Ammanford Carmarthenshire SA18 3AR swn-y-gwynt.dayhospital@wales.nhs.uk Tel no: 01269 595473	**Aberystwyth CMHC** **Gorwelion Resource Centre** Llanbadarn Road Aberystwyth Ceredigion SY23 1HB CMHT.Aberystwyth@wales.nhs.uk Tel No: 01970 615448

Individuals are usually allocated to a CMHC or CMHT based on their registered GP, however support can be provided by the closest team, who will work in partnership with the designated CMHC or CMHT, maintaining a collaborative approach and providing consistent feedback.

Operational Procedures

The following section describes a number of processes for the teams' successful operation.
Principles of a CMHC:

Hours of Operation

The centres are operational seven days a week via association with the Mental Health Liaison Service (MHLS) and comprise of the following:

Crisis Resolution and Home Treatment Team (CRHT) hours of operation in community settings 09.00am to 21.30pm, 7 days a week

Community Mental Health Teams core hours of operation 09.00 am to 17.00 pm 5 days a week.

Mental Health Liaison Service –based in District General Hospitals 24 hours a day, 7 days a week.

Mental Health Liaison Service

The Mental Health Liaison Service (MHLS) provides assessment for individuals presenting with mental health concerns in the Accident & Emergency Departments in District General Hospitals (DGH) as well as providing mental health care to patients being treated for physical health conditions in a DGH setting. The role of the MHLS includes:

- Assessment of ongoing mental health needs and arrangement of suitable aftercare.
- Support to patients, families and treating medical teams.
- Advice in relation to clinical care or diagnosis in hospital.
- Advice, teaching, and support to our DGH colleagues on mental health presentations, management of risk and advice on the use of the Mental Health Act.

The MHLS will identify individuals to the CMHC who require further assessment or home treatment with the CRHT or Care Coordination from the CMHT.

The MHLS teams are located in their respective DGH sites and will facilitate assessments as required. The MHLS can access the CRHT or the CMHT without referral. The team will provide continuation of assessment for up to fourteen days or provide home treatment and accept a request for Care Coordination under the Mental Health (Wales) Measure (as directed by the service).

HUDDLE

The CMHC Huddle is a morning meeting which follows the daily Directorate Bed Conference meeting. This brings together the Adult Mental Health Teams within a locality to ensure seamless joint working and information sharing.

- The Huddle comprises team leaders from CMHT, CRHT, MHLS, and Local Authority.
- Senior Nurses can be an optional member of the Huddle where issues need to be escalated or complex issues need to be addressed.
- An overview is provided from each team of any clinical challenges for the day.
- Opportunity used to create a plan for the day and work together to support deficits in a team's capacity.
- Identify joint working, if required to support an individual.
- Identify any individual at risk of admission and establish a contingency plan.

On completion of a nightshift the MHLS will adhere to the following:

A handover will be provided from MHLS to the CMHC, which will comprise of the CRHT and the CMHC duty practitioner from the CMHT. This will enable further assessment to be undertaken by either team, when indicated by MHLS staff. Individuals at risk of admission will be assessed by the CRHT to ensure that assessment and treatment at home is offered as the least restrictive option.

Crisis Resolution and Home Treatment Team (CRHT)

The CRHT team seeks to reduce acute distress, minimise immediate harm and improve overall functioning by providing a rapid assessment and treatment service to individuals who would otherwise require hospital admission. These services are provided in a variety of settings including individuals' homes, CMHC sites and local A&E departments.

The CRHT will:

- receive urgent referrals from GP, CMHT, and 111, conducting comprehensive assessments in various settings, including patients' homes. New referrals should not be expected to attend A+E for an assessment to be carried out.
- provide assessment for up to 14 days – (on day 14 an individual meets the criteria for and becomes a 'Relevant Patient' under the Mental Health Measure (Wales) 2010 where a CTP is required and progression onto treatment caseload).
- provide intervention for up to 6 weeks for individuals under CTP, this also includes individuals who are being co-ordinated by CMHT.
- problem solve acute social or interpersonal crisis.

- assess and manage risk using a person-centred approach.

- provide continued assessment or allocate for Care Co-ordination if requested from Liaison staff in order to facilitate a unified approach.

- work collaboratively with CMHT to determine eligibility for ‘Relevant Patient’ Status.

- Where contact is made from individuals that are not on the home treatment caseload every effort should be made to support the individual in getting the correct help and deliver intervention without referrals**.**

CRHT Caseload Management

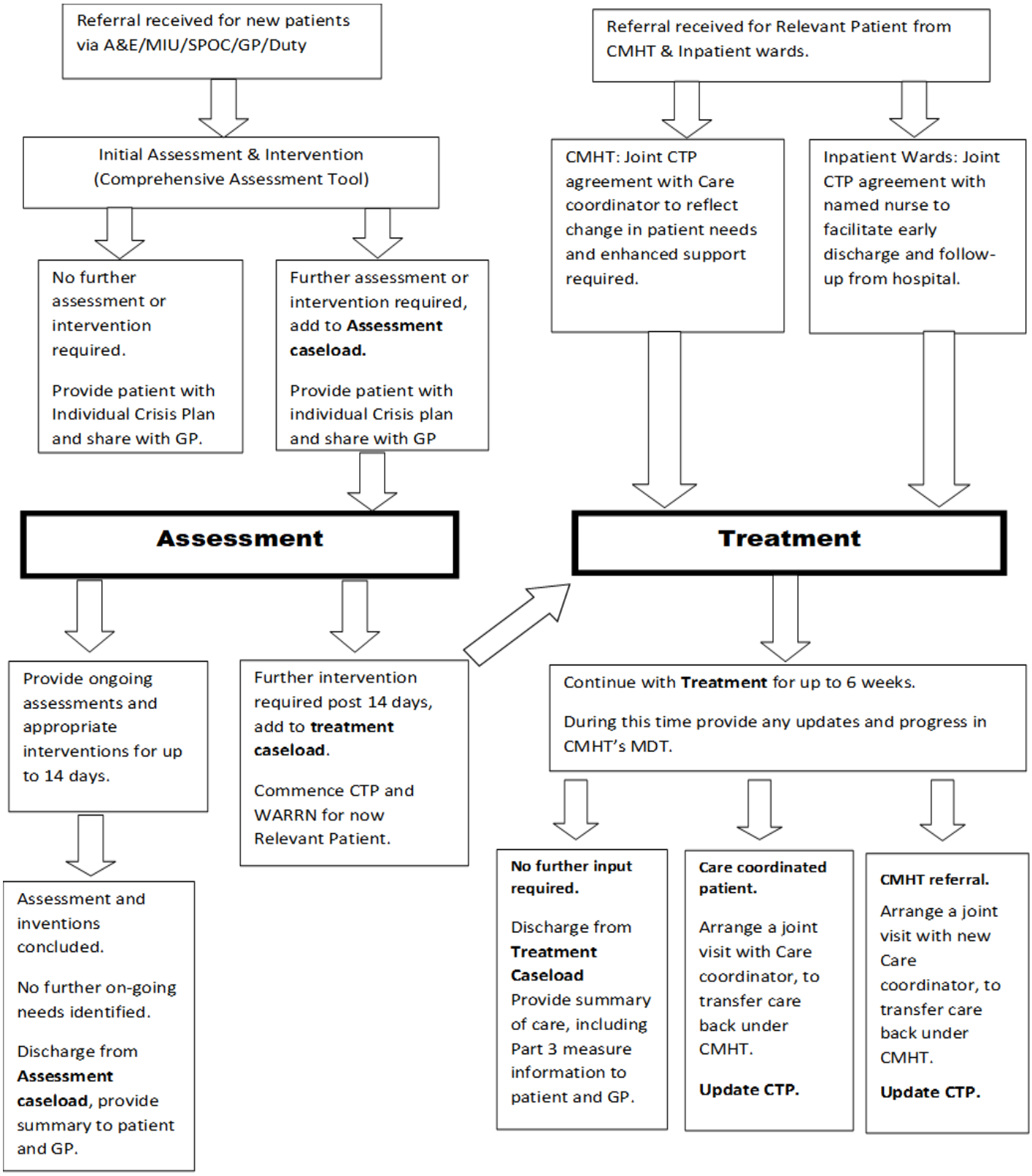
The caseload will be reviewed on a daily basis with any emerging concerns escalated to the clinical lead and reviewed weekly with the Advanced Nurse Practitioner or medical staff.

Case load management will be divided into Assessment and Treatment.

The team will identify from individual assessments, and risk management plans, the frequency and intensity of the contact required to undertake the care. The service will manage the case load collectively as a team. For new individuals under assessment, they will not be referred for care co-ordination until the outcome of the assessment determines eligibility for ‘Relevant Patient’ status.

When managing a caseload collectively every member of the team will be aware of the issues concerning each client on the case load and have a working understanding of the care plan and risk assessment for each client. When delivering home treatment the individual will already be allocated a Care Co-ordinator or arrangements will be underway to allocate care co-ordination where required.

All Multi-Disciplinary Team discussions and rational for decision making must be recorded on the electronic patient record (Care Partner). The CRHT will hold a weekly MDT, to discuss complex patients and the current caseload. Invites to this meeting can be extended to the CMHT team leaders, Psychology AMH, IPTS, LPMHS, CDAT, Neurodiversity and DDAS staff. This will give the opportunity to discuss and review joint work and provide a forum for information sharing. Minutes of these meetings will be taken by the Care Co-ordinator or person completing the assessment, and the information documented on each individual’s Care Partner Records.


Referral received for new patients via A&E/MIU/SPOC/GP/Duty
Initial Assessment & Intervention (Comprehensive Assessment Tool)
No further assessment or intervention required.
Provide patient with Individual Crisis Plan and share with GP.
Further assessment or intervention required, add to **Assessment caseload.**
Provide patient with individual Crisis plan and share with GP
Assessment
Provide ongoing assessments and appropriate interventions for up to 14 days.
Assessment and inventions concluded.
No further on-going needs identified.
Discharge from **Assessment caseload**, provide summary to patient and GP.
Further intervention required post 14 days, add to **treatment caseload**.
Commence CTP and WARRN for now Relevant Patient.
Referral received for Relevant Patient from CMHT & Inpatient wards.
CMHT: Joint CTP agreement with Care coordinator to reflect change in patient needs and enhanced support required.
Inpatient Wards: Joint CTP agreement with named nurse to facilitate early discharge and follow-up from hospital.
Treatment
Continue with **Treatment** for up to 6 weeks.
During this time provide any updates and progress in CMHT's MDT.
No further input required.
Discharge from **Treatment Caseload**
Provide summary of care, including Part 3 measure information to patient and GP.
Care coordinated patient.
Arrange a joint visit with Care coordinator, to transfer care back under CMHT.
Update CTP.
CMHT referral.
Arrange a joint visit with new Care coordinator, to transfer care back under CMHT.
Update CTP.

Community Mental Health Team (CMHT)

The service will offer secondary mental health care for 'Relevant Patients' under the Mental Health (Wales) Measure 2010. They provide urgent or routine mental health assessments from the duty team and provide Care Coordination.

The CMHT Duty Practitioner will also be available as a point of contact for the Mental Health SPOC- (111 option 2) who would then assume this role where an individual may be in need of a mental health assessment but does not require any other form of medical assessment or intervention.

The provision of services must be centred on the needs of the individual and the support needs of their families and carers. The team must ensure that their rights to dignity and choice are respected at all times.

The CMHT's aim is to:

- Promote health and recovery.
- Prevent mental illness.

To effectively address the needs of individuals and promote better outcomes, the clinical practitioner should provide time limited interventions and access to services such as:

- Advice and support for mental health problems and promote good mental health.
- Supporting individuals to connect with social activities (for example, libraries, leisure and social activities, or faith groups).
- Coordination and delivery of care through high-quality, co-produced, personalised care and support planning.
- Effective support, care and treatment for co-occurring drug and alcohol-use disorders.
- Help in accessing local opportunities for work and education, volunteering, and training services.
- Appropriate medication and medication management.
- Assistance in accessing suitable accommodation.
- Referral to Welfare Benefit advisory services.
- Evidence-based interventions, including psychological treatments, such as coping skills, problem solving, and/or distress tolerance.
- Services enabling access to mental health information and online resources.
- Access to specific support groups (Hearing Voices groups, or problem-specific support groups, for example for diabetes or depression).
- Relapse prevention programmes.
- Support and advice for carers and families.

Referral Process

Individuals referred to the CMHC must have had a consultation with the referrer in the previous 48 hours. This can be virtual, face to face or by telephone. An urgent referral to the service will be triaged via telephone **(Appendix 1)** by the CMHC duty practitioner. The CMHC will accept appropriate referrals to provide assessment or home treatment.

Referrals will need to include the details about the presenting problem as well as:

- Risks - is the individual at risk to self or others?
- Family History, Risk history.
- Substance misuse.
- Current medication (physical & psychotropic).
- Has the referral been discussed with the individual?

Referrals must be scanned into the patient's electronic record.

Referral from GP's and/or other services will be accepted if the following conditions apply:

- Suspected severe or enduring mental disorder.
- Complex mental disorder or severe psychological disturbance where significant risk is a factor.
- Mental disorder associated with significant and/or urgent risk.
- Complex needs and significant deterioration of mental state.
- Assessment request under Part 3 of the Mental Health Measure (Wales). This enables individuals (previously in receipt of Secondary Mental Health Services) to self -refer directly back into Secondary Mental Health Services within 3 years of their discharge.

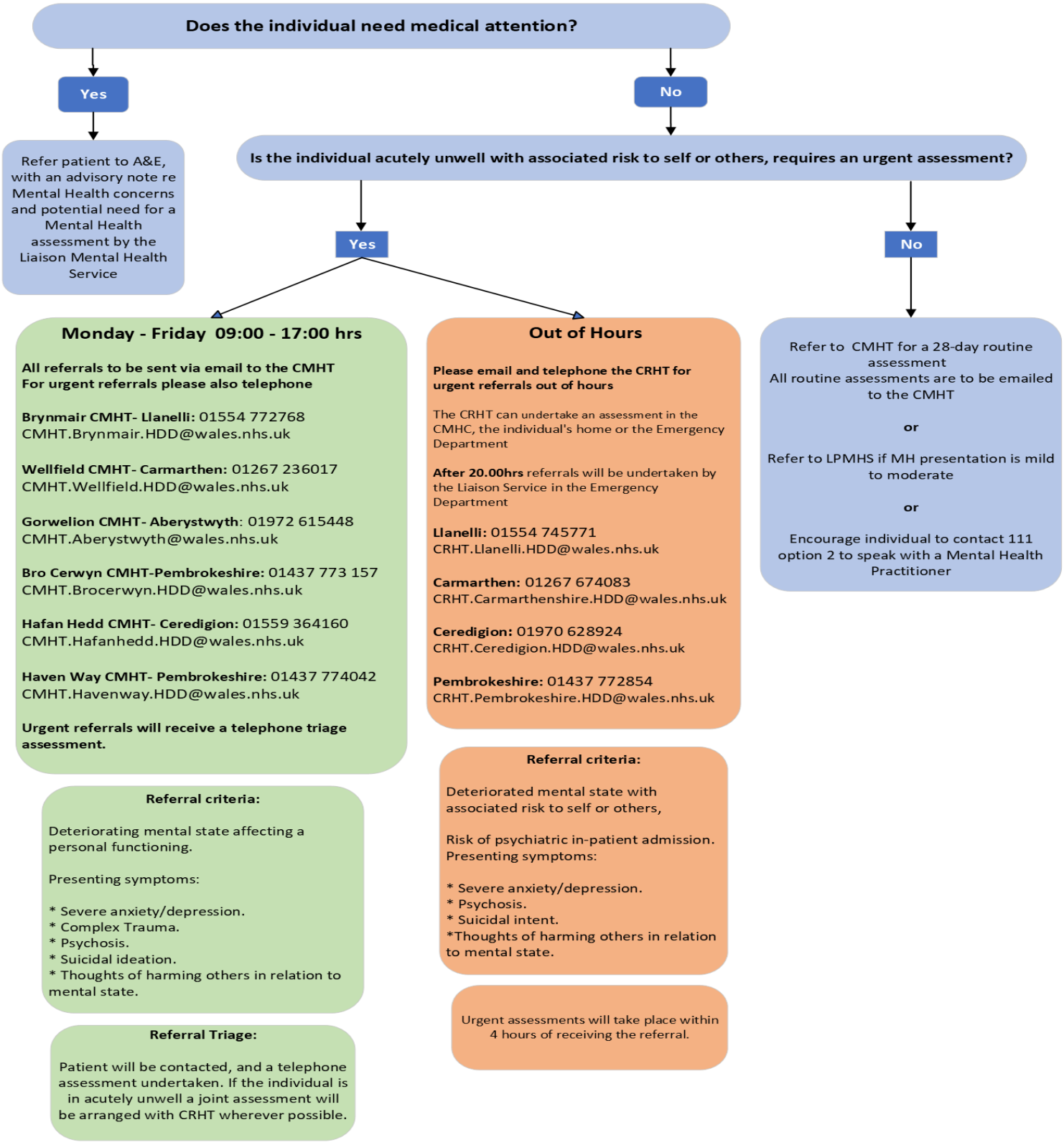
Referral Screening Meeting

This meeting will be held separately from a multi-disciplinary team meeting (MDT). Attendees will include the Team Manager, Consultant Psychiatrist, Local Authority Lead, Occupational Therapist, Psychologist and Administrator. A minimum of two professions are required in order for the meeting to take place.

The purpose of the meeting will be to:

- Screen incoming referrals.
- Agree referrals to be redirected to LPMHSS for screening for low or high intensity i.e., IPTS, CDAT or other.
- Allocate referrals that require an assessment with a nurse or Social Service Wellbeing Assessment or Occupational Therapist or any joint assessment required.
- Allocation of assessments, including inpatient allocations.

CMHC referrals are currently managed through this pathway:



CMHC Duty

Role and Responsibilities

- To manage professional telephone line and receive and screen urgent referrals or calls from GP, 111 option 2 Mental Health SPOC, Welsh Ambulance Service Trust, Police and Liaison.
- Undertake face to face urgent assessments when required / or joint urgent assessments with the CRHT team.
- Accept referrals under Part 3 of the Measure. Under the Mental Health (Wales) Measure 2010, individuals who have been in receipt of support from secondary care services (CMHC) and have been discharged within the last three years are able to self-refer directly. They are entitled to request an assessment without the need to go via their GP. Following assessment, a written outcome must be sent within 10 days.
- Ensure two daily urgent referral slots have been allocated and that staff are notified of any urgent referrals that require assessment.

In order to ensure the efficiency of CMHC, Duty calls for absent CPN's will be directed to deputies and all medication queries will be directed to the medical secretaries. Local Authority calls are to be directed to the LA secretary.

CMHC Team Time

A monthly meeting for the teams with an agenda agreed by the CMHC and inclusion of Reflective Practice.

Management and Co-Ordination

The CMHC will be managed, and staff clinically led by the Band 7 Clinical Lead who is on duty. In the event the two clinical leads are absent there will be a nominated coordinator to organise home treatment visits required and who will facilitate referrals for assessment.

Assessment

An assessment can take place in a range of settings including the person's home. All assessments undertaken by the CMHC will be completed on a Comprehensive Assessment Tool form **(Appendix 2)** and will:

- Determine whether the service user has a mental health problem which will require admission to the acute in-patient services.
- Determine the level of risk to self or others.

- Determine what immediate action is required.
- Determine if the service user requires a further period of assessment of up to 14 days, which will be undertaken using a Comprehensive Assessment Tool form.
- Determine if the individual can be signposted/connected to an appropriate service or be referred back to the referrer with advice.

All of which is to be clearly documented on Care Partner and shared with the individual and their GP.

The Practitioner should provide the person with an opportunity to be assessed alone and for further discussions along with their family/carers. Wherever possible families/carers should be sensitively offered the opportunity to speak to the assessing practitioner alone to discuss any issues or give collateral information/history.

For onward referral to the CRHT the team will need to demonstrate the need for assessment and treatment and outline previous attempts to provide this. The outcome of the assessment will be communicated to the referrer and relevant others in writing and a copy scanned to the patient's electronic clinical record. This will be an individualised letter and will outline essential clinical information and include risk.

In accordance with Part 3 of the Mental Health (Wales) Measure all discharged Relevant Patients are entitled to self-refer for assessment for 3 years post discharge. Assessment times should, as a minimum, match the usual standards for community mental health teams – namely that emergency referrals are to be seen within 4 hours of request, urgent referrals within 48 hours of request, and all other referrals within 28 days of request. The Regulations made under Part 3 require that a copy of the report be provided to the individual who was assessed no later than 10 working days after the conclusion of the assessment.

Failure to Attend Assessment

If an assessment has been booked and the individual does not attend, the assessor should make all attempts to contact the patient and if appropriate, family members and other known agencies stated in the referral. All staff should exercise a level of professional curiosity in line with the Health Boards 887 - Monitoring Vulnerable People Who Were Not Bought or Did Not Attend procedure;

Ordinarily an adult with capacity to make decisions regarding attending appointments, who chooses not to attend an appointment would not be made the subject of a Safeguarding Report, even if the decision not to attend might be considered an unwise decision. However, there may be other factors present which would suggest that the individual is an 'Adult at Risk' and the decision not to attend may be as a consequence of abuse or neglect.

In cases where an adult does not attend an appointment, it may not be apparent that the individual is an 'Adult at Risk', this is especially the case when the individual has not been seen previously, or not for some time. Consequently, it can be difficult to gage if this is a case of an individual not being brought to the appointment. Consideration needs to be given to identifying any potential vulnerabilities which

might suggest that the individual may be an ‘Adult at Risk’ and that the electronic record should reflect ‘Was Not Brought’ rather than ‘Did Not Attend’.

If the assessor is unable to make contact, then the referrer should be contacted in order to agree a plan or informed of next steps i.e. offer a further appointment noting on the appointment letter that this is the second appointment due to non-attendance, or to jointly undertake a welfare check **(Appendix 3)** with the Police if there is a concern. Advice can be sought from the Health Board Safeguarding Team if required.

Gatekeeping

Request for an informal admission must be discussed with the CMHC to ensure that alternative home treatment options have been considered to allow for least restrictive practice. Following this if an informal admission is indicated, this should be discussed at the Directorate Bed Conference meeting or in urgent circumstances with the Duty Service Manager. This is to ensure that all treatment options have been offered or considered to meet the principle of least restrictive option for providing assessment and care as described in the Mental Health Act 1983 Code of Practice.

Conveyance

It is important to balance patient autonomy with patient safety at all times. Individuals should always be conveyed in a manner which is most likely to preserve their dignity and privacy whilst managing any risk to their health and safety or to other people.

The St Johns Mental Health Ambulance operates 24 hours a day, 7 days a week across the Hywel Dda UHB Footprint. The service will be operationally staffed from 10.00am – 10.00pm and will then default to an On-Call provision from 10.00pm – 10.00am. There will be a two-person crew available to support staff with mental health transport requirements. Please see appendices for documentation detailing processes and procedures including:

- Conveyance Protocol **(Appendix 4)**
- Pathway **(Appendix 5)**
- Risk Assessment **(Appendix 6)**

The St. John’s crew will aim to join the daily Directorate Bed Conference meeting at 09.30am and 3.30 pm. This will act as a point of co-ordination for daily transport arrangements and will be overseen by the Chair. As set out in the pathway (**Appendix 5**) after 5pm the Duty Clinical Co-Ordinator will oversee the Transport Co-ordination.

St John’s Ambulance are to be contacted in the first instance. Any conveyance made by staff would require a dynamic risk assessment (the process of continually observing and analysing risks and hazards), applying the risk assessment principles detailed in **Appendix 6** (as above).

Transport

The CMHC has the use of two lease cars allocated to be shared between the teams, and the local CMHT. This use is for visiting clients in community settings. Priority of use should be decided between both team leaders, with priority given to longer journeys and out of area placements. The use of St John's Ambulance transport is available, for journeys that require patient transfers, if appropriate.

As outlined in all staff job descriptions, all staff are required to have the ability to travel between health board sites. Staff are able to claim any expenses incurred via e-expenses. This will require staff to have business insurance, which ensures staff are able to claim –as per Hywel Dda UHB 389- Expenses Policy (*opens in new window).*

Individuals Under Police Arrest

The CMHC will not undertake assessments in police custody, however, will accept a referral for an individual under arrest from a healthcare staff member from a general hospital. On completion of the assessment an outcome form will be completed and emailed to the Custody Sergeant who is responsible for that individual **(Appendix 7).** There is an agreed pathway between HDUHB and Dyfed Powys Police **(Appendix 8).**

Section 136

This section should be read in conjunction with 395- Section 136 – 1983 Mentally Disordered Persons Found in Public Places Procedure, (*opens in new window*) the Policing and Crime Act 2017 and The MHA Code of Practice.

Wherever a Police Officer encounters an individual who appears to warrant the provision of Section 136 of the Mental Health Act, they should first attempt to contact an appropriate mental health professional as described in **Appendix 9** to seek advice, if practicable. This will be via the Duty Clinical Co-Ordinator. If detention under Section 136 is required, the Mental Health Practitioner will advise which place of safety is to be used.

Where admission to hospital is indicated, following the Mental Health Act assessment it is the responsibility of the assessing Medical Practitioner to identify an inpatient bed for the patient, assisted by the Directorate Bed Conference meeting or Duty Clinical Co-Ordinator.

The AMHP is responsible for arranging the transportation of the patient to the identified admission bed. The Directorate Bed Conference meeting or Duty Clinical Co-ordinator will support this process using St Johns Ambulance.

Use of Telephone calls

A telephone screening assessment will be undertaken using A**ppendix 1,** but a follow up review must be undertaken face to face unless this is not possible, then reason should be clearly documented on Care Partner.

The treatment plan is delivered predominantly by face-to-face contact within the community setting. This may be supplemented by telephone calls, in order to provide information and / or confirm appointments.

The patient must be given a date and time for the next contact at the conclusion of assessment or following each CRHT or CMHT visit or intervention. This may be confirmed by telephone call too. Any changes to planned visits must be documented including the reasons why or if there is a reason a pre-planned visit cannot be arranged.

Telephone contact alone will only occur in exceptional circumstances and on these occasions the reason for the appropriateness and rationale of this type of contact will be clearly documented in the care plan / risk assessment and management plan.

All patients should have access to service phone numbers that are accessible and answered in a timely manner during operational hours, outside of this, an answer phone message with clear instructions on where they can access support. Where callers who are not currently with a service, they should be appropriately supported to access the right person.

Other forms of Communication

Communication with individuals can be via text messages utilising practitioners work phones, with a clear understanding provided to the individual around the non-urgent use of text messages, due to unexpected absence or of other commitments.

A summary of text messages should be recorded in Care Partner.

Team generic email addresses can be provided to individuals to aid communication with understanding this is for non-urgent use. All generic email addresses must have an automated response with a clear message of how to gain access to emergency care.

No other form of digital platform should be used or social media service for communications with individuals. An exception to this is for the purpose of communication with someone with a disability or language barrier in which software to aid communication is used with agreement from the line manager.

All communication will be in line with Health Boards policies; 320- Acceptable use of Information and Communication Technology Policy *(opens in new window)* and 465- All Wales Social-Media Policy *(opens in new window).*

Risk Assessment and Management

A primary function of all CMHC / CMHT Practitioners is to undertake clinical assessments in varying contexts. Clinical assessments are multidimensional in approach with information gathered from many sources, including the service-user's opinions and other interested parties such as family members.

Through the clinical assessment process, Practitioners develop an understanding of the individual to identify needs which can be supported and risks which can be managed. This helps effective person-centered care to be planned for each service user.

The assessment of a person's needs, vulnerabilities, and safety should be a part of every assessment and 'risk' should not be used to determine care management in isolation of other factors.

All staff should use their clinical judgement when assessing someone who has a risk of harm, whether to themselves or others, and in the event, they are concerned about the person and their safety, should conduct a risk formulation using the Wales Applied Risk Research Network (WARRN) Tool **(Appendix 10)** to place the person's safety considerations in context with their strengths and difficulties.

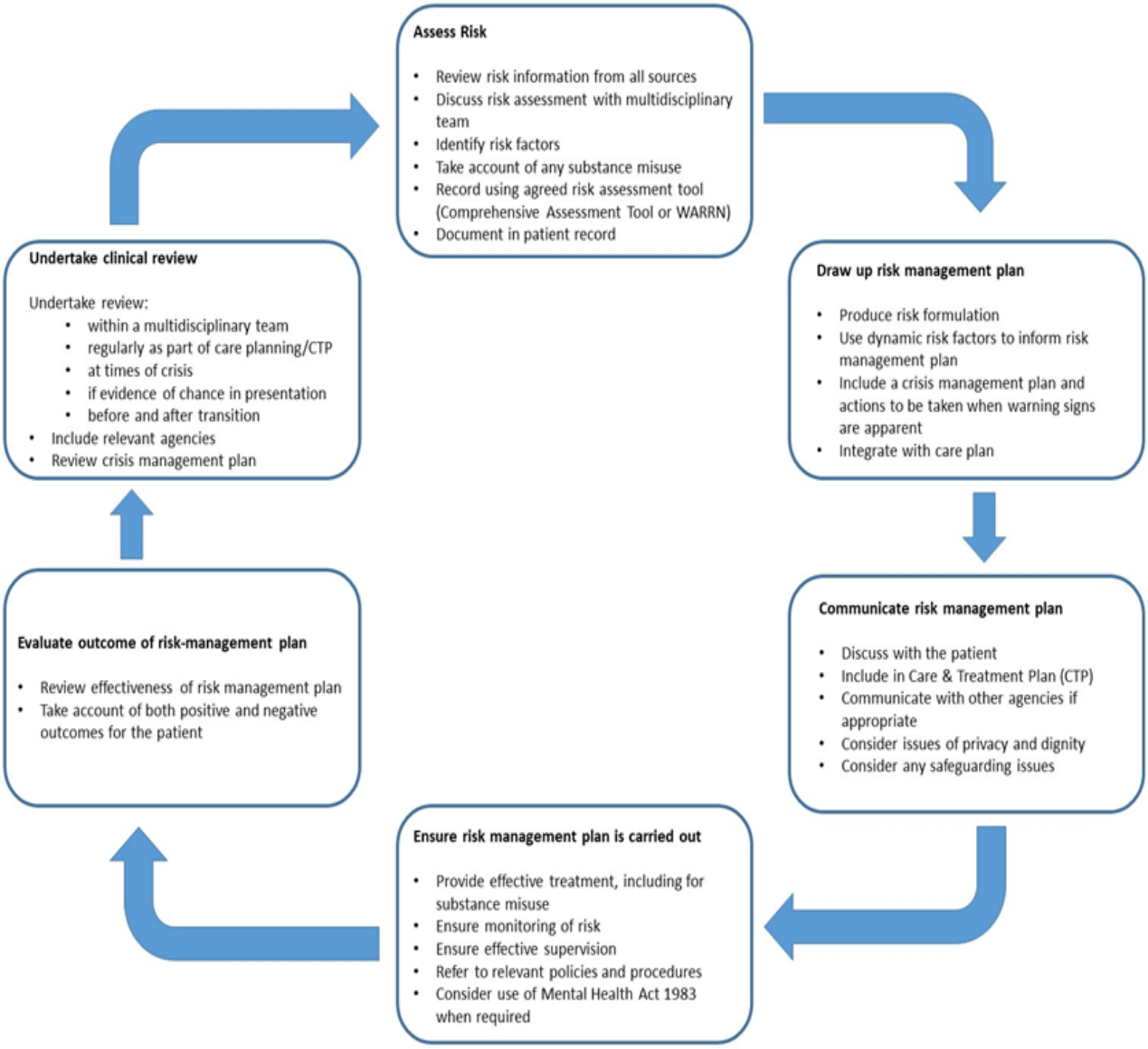
Risk formulation is a collaborative process between the person and a mental health professional that aims to summarise the person's current risks and difficulties and understand why they are happening in order to inform a treatment plan. Formulation typically includes taking into consideration historical factors and experiences, more recent problems, and existing strengths and resources.

A risk assessment should take into account that risk is dynamic and, where possible, specify key risk indicators which would trigger a review of risk management plans. Risk formulation brings together an understanding of personality, history, mental state, environment, potential causes and protective factors, or changes in any of these.

It should aim to answer the following questions:

- What is the nature of the risk?
- What is the probability of the risk occurring?
- How imminently might the risk occur?
- What is the likely severity if the risk does occur?
- What are the key risk indicators or risk reducing factors?

The purpose of any risk assessment process is to enable a risk management plan to be developed. Risk management plans should consider how risk can be safely managed which may include options such as treatments, and control measures. Considerations should also be given to how the person has managed these feelings and risks in the past and what has been helpful to them previously in achieving a positive outcome.



In response to any identified risks Practitioners within the CMHT / CMHC will develop a person-centred safety plan with the individual. This is a written, prioritised list of coping strategies and/or sources of support that the person can use to help overcome a period of crisis. Components can include recognising warning signs, listing coping strategies, involving friends and family members, contacting mental health services, and limiting access to self-harm methods, which are to be referenced in the Care and Treatment Plan. Where appropriate and with the person's consent, sharing information including risks, management plan and contact numbers with key individuals which may include family members / carers.

Care Co-ordination

The Mental Health (Wales) Measure Code of Practice is specific as to which professionals can act as Care Coordinators. They must be mental health professionals with appropriate skills and qualifications including:

- Social Workers
- Mental Health or Learning Disability Nurses
- Occupational Therapists
- Psychologists
- Doctors
- Dieticians
- Physiotherapists
- Speech and Language Therapists

The MHM places a duty upon the service provider to appoint a Care Coordinator as soon as reasonably practicable after the individual becomes a 'Relevant Patient'. This should be in all, but exceptional circumstances, within 14 days. Whilst Part 2 Regulations recommend that a CTP be produced within 6 weeks and distributed within 2 weeks of its completion.

Role of Care Co-ordinators

The 'Relevant Patient's' Care Co-ordinator will be a professional working with them in secondary mental health services. Their Care Co-ordinator will be their principal source of information and will be responsible for seeking their active involvement and engagement with the care planning process. The Care Co-ordinator will also be ultimately responsible for ensuring the person has a written Care and Treatment Plan and that it is reviewed and updated.

The duties and functions of Care Co-Ordinators are set out in detail in the Code of Practice and amount to ensuring they are actively working with, and co-ordinating the care and treatment of the people they are responsible for by:

- collaborating with the 'Relevant Patient' and the 'Relevant Patient's' mental health service providers with a view to agreeing the outcomes which the provision of mental health services is designed to achieve.
- ensuring that a Care and Treatment Plan is developed and co-produced within 6 weeks of the appointment of the Care Co-Ordinator.
- ensuring Care and Treatment Plans are reviewed and revised.
- providing advice to service providers on the effective co-ordination of the care which is delivered.
- keeping in touch with the 'Relevant Patient'. All patients will have a minimum of monthly contact and one home visit in a 6-month period. The Care Co-Ordinator may also choose to keep in touch with family and carers where appropriate or necessary.

- Service users who are subject to Section 117 of the Mental Health Act will have an allocated Care Co-Ordinator and a Care and Treatment Plan as is required by HDUHB 688- Section 117 - After Care Policy *(opens in new window).* Consideration should be given to the nature of the ongoing needs of the service user and the core skills of the Practitioner when allocating the role of Care Co-Ordinator.

Eligibility for Care Co-ordination

Decisions on whether someone should be accepted as a 'Relevant Patient' should always be based on their health and social care needs as a whole and not on diagnosis alone. However, following an assessment of need, priority will be given as shown below:

- Individuals over the age of 18 who require specialist support for mental health conditions.
- Individuals who have been treated for a severe and enduring illness in the past, but their condition is stable and current presentation is stable but at risk of relapse.
- The individual needs support in a domain of the Care and Treatment Plan directly relating to their mental health.
- There is a complex and severe mental disorder that is current in presentation.
- Individuals with severe, difficult to manage and persistent mental illness, such as schizophrenia, severe depression, bipolar disorder, or personality disorder.
- Individuals with longer term disorders of lesser severity but which are characterised by poor treatment adherence requiring proactive follow up.
- Any disorder where there is significant risk of self-harm or harm to others (e.g., acute depression, anorexia, high levels of anxiety).
- Pregnant mothers suffering any type of mental disorder.
- Individuals with co-occurring substance use and mental health issues, who require care co-ordination.
- Individuals who have had a period of home treatment, who require ongoing input from CMHC.

Co-occurring Mental Health and Alcohol/Substance Use

Individuals with co-occurring alcohol/substance use problems are defined as those with severe mental illness and drug and/or alcohol problems. This group are likely to meet the eligibility criteria for Care Co-ordination.

It is acknowledged that individuals may often present particular risks to themselves or others and require robust care co-ordination. Those with a co-occurring diagnosis will be the primary responsibility of the mental health services. Such individuals should be referred as necessary to the Community Drug and Alcohol Team for expert advice or a specific treatment package. The Community Drug and Alcohol Teams will also give advice as necessary to those providing medically assisted withdrawal programmes to individuals with a co-occurring diagnosis.

Regular communication with CDAT and DDAS should be maintained through regular meetings and attendance at MDT meetings.

In order to ensure that a collaborative approach is being delivered within local services, a Local Co-occurring Mental Health, and Substance Misuse Framework has been jointly produced and agreed Hywel Dda Co-occurring Mental Health & Substance Misuse Framework (*Opens in new window*).

Co-occurring Mental Health and Substance Misuse Practitioner

Individuals with co-occurring mental health and substance misuse problems, often find it hard to access treatment, remain engaged in treatment and have worse overall outcomes. The role of the Co-occurring Mental Health and Substance Misuse Practitioner is to

- work with individuals who meet the criteria for secondary mental health services, require a CTP and also have substance misuse concerns.
- provide support and advice to both teams in working with substance misuse and mental illness.
- provide strong communication links and a shared joined up approach to working with these individuals.

Care Co-ordination: Inpatient Services

For patients under care co-ordination on admission:

Discharge planning should commence at the point of admission, if not before as part of a joint discussion with the Care Coordinator. During any inpatient admission, the service user will be allocated a named nurse on the ward who will work with the Care Co-Ordinator to ensure the needs identified on the Care Plan are met. The Care Co-Ordinator will:

- maintain a minimum of weekly contact with their patient whilst they are in hospital.
- work collaboratively with the service user and inpatient staff to devise a Care and Treatment Plan.
- attend Business Meetings to give a clear overview of the Care and Treatment Plan whilst in hospital and of the discharge plan.
- feedback to the Business Meeting on the progress made and provide an update on discharge plans.

For those inpatients not under care co-ordination on admission:

When individuals are admitted to inpatient wards, they meet the criteria for a Care and Treatment Plan as a ‘Relevant Patient.’

- Patient to be discussed with relevant CMHT team leader at the next Business Meeting with a view to allocate a Community Care Co-ordinator within 7 days.
- Community Care Co-ordinator to meet with patient within 7 days of allocation.

- Care Co-ordinator to work collaboratively with patient and inpatient staff to devise a Care and Treatment Plan.
- Feedback to the Business Meeting on progress made and provide an update on discharge plans.

*Please see **Appendix 11** for flowchart.*

In accordance with the recommendations form the National Confidential Inquiry into Suicide and Safety in Mental Health (NCISH), following discharge from in-Patient services to the community, a follow up review within 72 hours will be undertaken by the CRHT, or by the existing Care Co-Ordinator, if the individual is under the care of secondary care Mental Health Services; this will be agreed during the discharge planning meeting. The patient and carer are informed of the follow up appointment and onward plan before discharge from inpatient service (**Appendix 12).**

Transfer of Care Co-Ordination

The Care Co-Ordinator will make a Transfer of Care Co-Ordination request via a Transfer of Care document unless the individual concerned is subject to a Community Treatment Order where the Responsible Clinician should make the referral. For transfers external to the Health Board the following will also be applicable.

The referral will be addressed to the Manager of the team requested to take over the individuals care and treatment. The referral will include:

- The reason for Transfer of Care request.
- An indication of which professional groups need to be involved with the individuals Care and Treatment.
- A brief summary of the history of the individual: including diagnosis, treatments/interventions undertaken in the past.
- A description of current care and treatment being undertaken, goals outlined in the Care Plan, social situation.
- Commissioned care package and funding arrangements where appropriate.
- Registration with a GP and transfer of medical information.

The accepting CMHC/CMHT will liaise with the Care Coordinator or Responsible Clinician making the request, to arrange a CTP handover meeting.

Transfer from SCAMHS to AMH Service

In line with the Health Board's SCAMHS Transition Guidelines (*opens in new window*) The formal transfer/referral will be made using the Care Partner Clinical Programme and in line with requirements of the Mental Health Measure (Wales) 2010 Part 2 Care and Treatment Planning. A Transition Referral form will be completed by the S-CAMHS CTP coordinator. The transfer/referral **will not** be treated as an external referral as the young person is already receiving Specialist Services from the Health Board.

When the initial assessment/discussion have been completed, the identified care coordinator from each service will ensure that appropriate levels of liaison take place with the young person, parents/carers and other professional and/or agencies involved via the CTP Planning Meeting.

Care and Treatment Plan

The Measure requires the Care Co-Ordinator to collaborate with the 'Relevant Patient' and the 'Relevant Patient's' mental health service providers to agree outcomes and prepare the Care and Treatment Plan. The Care and Treatment Plan will reflect all domains of a Care and Treatment Plan with specific reference to:

- Finance and Money
- Accommodation
- Personal care and Physical wellbeing
- Education and Training
- Work and Occupation
- Parenting or Caring responsibilities
- Social, Cultural and Spiritual
- Medical and other forms of treatment, including psychological interventions

A Care and Treatment Plan should include information against each of these areas as to:

- what outcomes the person is seeking.
- what services are being provided or what actions are being taken.
- when and by whom.

The above will be contained in a person-centred CTP in line with the statutory requirements of the Mental Health (Wales) Measure 2010. Individuals who are receiving care from Secondary Mental Health Services will have a CTP.

Care and Treatment Plan Review

Once a person's Care and Treatment Plan has been agreed and services are being delivered, the Care Co-Ordinator has an ongoing responsibility for monitoring the implementation of the Plan. Such monitoring should include:

- continuing assessment of the person's mental health needs and risks.
- ensuring that services are being delivered as agreed.
- whether the specified outcomes remain relevant and are being achieved.

The Care Co-Ordinator may review the Care and Treatment Plan for a 'Relevant Patient' at any time or following a significant change in the Individual's presentation. Part 2 Regulations require

that a review must be held, as a minimum, at least once in any twelve-month period. Reviews must be focussed on the Care and Treatment Plan and the needs of individual. The review can also be arranged, at any point, should there be an identified change in presentation and held on request by the 'Relevant Patient' or a carer.

It is good practice to meet with the 'Relevant Patient' to discuss the review meeting two months before to identify achievement of outcomes, and to obtain a view on further outcomes or actions before the meeting. This should also include who will attend the review.

Care and Treatment Plan Review Guidance

- A date, time and venue must be agreed with adequate notice for all attendees with an agreed period allocated for the review.
- A chairperson will be agreed who will ask attendees to introduce themselves.
- CTP domains will be updated to identify achievement of outcomes or identify the need for additional support.
- Details of the meeting discussion will be recorded on the CTP Review documentation.
- Relapse indicators and CTP contingency plans must be reviewed and updated as required. This will be shared and agreed with the patient and the patient given a copy.

Multi-Disciplinary Team meetings

A weekly multi-disciplinary meeting (MDT) will also be attended by a range of professionals including the Nursing Team, Local Authority Team, Pharmacy, Psychology, Occupational Therapists and Medics.

A designated chairperson will ensure the effective running of the meeting adhering to a standard agenda. The minutes and action log are to be stored in Share-point. The Care Co-Ordinator is responsible for documenting the clinical discussion in care partner.

Purpose:

- Assessment feedback – To discuss complex cases post assessment where immediate consultation was not required.
- Medication Queries – Advice and guidance on medication. Information sharing as required from the Pharmacist.
- Internal Referrals to Occupational Therapy.
- Internal Referrals to Psychology.
- Clinical discussion – for complex cases only – maximum of 2 per week with names provided ahead of the meeting to the administrator. 20 minutes are allocated, to include, required outcomes from the MDT discussion and a pen picture.
- To look at discharges and what is needed to facilitate discharge from CTP.

Medication Management

A current list of the individual's medication should be obtained from the Welsh Clinical Portal (WCP) or from the GP as soon as practicably possible. Any medication prescribed at the time for mental health is clearly explained as to its purpose and any side-effects to the individual and their family/carers as appropriate. A leaflet describing commonly used medications that will inform of any expected outcomes/side-effects to be give out as appropriate.

Any medication should be prescribed at the earliest opportunity in the case for home treatment and delivered promptly. Medication adjustments will be addressed by the Psychiatrist or the GP. Controlled Drugs medication that is stored specifically for CMHC use is to be kept stored and administered according to the Health Boards 268 - Medicines Policy *(opens in new window).*

Excessive medication in a patient's home

Any identification of excessive medication in an individual's home, should also be communicated to the GP and a risk management plan made. It is the duty of Practitioners to advise the patients and relatives on the correct destruction/disposal of unwanted medicinal products. Unwanted medicinal products must be returned to the community pharmacist for destruction.

It is not the responsibility of the Practitioner to return the medicinal products to the community pharmacy. Under no circumstances should Practitioners take surplus medicinal products into their possession from individuals/carers or next-of-kin or make any further use of them. However, Practitioners may hold temporary possession of medicines, in exceptional circumstances (for example, acting in the best interest of the patient/relative/carer or public interest and the action should be reasonable and in accordance with peer professional practice) in order to return them to the Community Pharmacy for destruction. It would be sensible to seek and document the agreement of the individual, carers, or next-of-kin. If there is not a carer or relative, the Practitioners line manager should be informed. All residual contents of ampoules or vials must be sent for disposal in the appropriate container in accordance with the aforementioned Medicines Policy.

Supporting Unpaid Carers

Unpaid carers of all ages are a fundamental focus within Hywel Dda University Health Board. Carers supporting friends and relatives are an important part of the health and social care system, and it is important to ensure they are valued and recognised for their contribution. Carers play a pivotal role in supporting those they care for to achieve their outcomes and enabling them to remain living in their own home. The Mental Health & Learning Disability Directorate are therefore committed to working to deliver support for carers of Mental Health and Learning Disability service users in our communities, and to ensure that the needs of carers are considered at every stage of their journey.

National data indicates that the presence of a carer can greatly reduce admissions to hospital and long term residential or nursing care. Supporting carers to live their life the way they want and maintain their caring role is therefore central to achieving this. It also fulfils our duty to promote the well-being of carers who need support in Wales, ensuring carers are supported to secure their rights and entitlements and to maintain their physical and mental health and emotional well-being.

The importance of supporting carers is also aligned with the Social Services and Well Being (Wales) Act 2014 which legislates for enhanced rights for carers of all ages and simplifies and consolidates the law, giving them equivalent rights to the person they care for. The Act also gives carers the right to choose whether and to what extent they are or remain carers. This recognition and support of carers of all ages also aligns to both the Welsh Governments and the West Wales Carers Strategy.

The important role of unpaid Carers has been recognised by the Health Board by assigning a specific Planning Objective, 2A: *"Work with key people across the organisation to develop local plans to support the delivery of the West Wales Carers Strategy 2020-25".*

It is the role of all team members within the CMHC and CMHT to recognize carers and to signpost/refer them to their local carer support services. Carers are in many situations fundamental to the success of CMHC for an individual experiencing mental health distress.

CMHC staff are expected to support Carers by:

- Providing Carers with written information that is pertinent to the individuals case for example -signs and symptoms of depression.
- Provide information on medication management as appropriate.
- Include Carers in crisis/contingency plan reviews and are invited to attend CTP reviews. Carers views and opinions are to be recognised and recorded appropriately.
- Sharing information about the individual they are caring for including risks, management plans and contact information where appropriate.
- Informing Carers of their right to a carers assessment and signposting accordingly.

N.B- You may need to share information without consent, where the safety and well-being of the individual or others may be at risk.

Case Closure

The CMHC will refer the service user to the appropriate mental health services / connected to other services where this is appropriate before they are discharged from the service.
When further care coordination is required preparation for discharge will include a handover with the appropriate CMHT at their weekly meeting.

A discharge summary **(Appendix 13)** will be written, and copies forwarded to the Individual, Care Co-ordinator / GP as appropriate.

Where a person has disengaged from the service without the agreement of the CMHC then the following should be arranged:

- A team review of the individuals illness and current problems. Review any concerns about potential relapse.
- Assess risk history and any future concerns as a result of disengagement.

- MDT discussion to review what further clinical actions are required e.g., contact family / carers / friends if appropriate.
- MDT discussion to decide whether any concerns necessitate informing others e.g., police, social services.
- All decisions must be recorded on the service user's Care Partner notes.

All Individuals who have been eligible to receive care under Part 2 of the Mental Health (Wales) Measure 2010 must be informed of their rights to a future assessment under Part 3 of the Measure.

Relationships with other teams and agencies

Mental Health Single Point of Contact; 111 Option 2

The Mental Health Single Point of Contact (MH SPOC) operates 24 hours a day, 7 days a week within the Mental Health and Learning Disabilities Directorate of Hywel Dda University Health Board. It is a well-being and mental health telephone triage service which can be accessed via the national 111 call line and selecting Option 2. Callers can self-refer, or calls can come from family, friends, carers.

It is an open access, all-age service and is open to anyone experiencing mental health crisis residing within the Health Board locality of Ceredigion, Carmarthenshire, and Pembrokeshire. This includes anyone visiting the area, including those who may be homeless or living in temporary accommodation.

Using a recognised triage tool and compassionate focused interventions. Mental Health Practitioners will assess the mental health needs of the individual and escalate as appropriate. They will connect individuals to the most appropriate mental health and well-being provision to meet their needs in a timely manner, including those with common mental health problems and those with more complex, acute, and high-risk presentations.

The triaging of urgent mental health requests for help, will ensure that service users, carers and referrers receive an efficient and timely response when accessing mental health services or needing advice, support, and signposting.

The Single Point of Contact (SPOC) team have agreed pathways into all the areas within the Mental Health & Learning Disabilities Directorate.

Professionals seeking advice and guidance can access the service by identifying themselves during the call, ensuring they are directed to the appropriate person for support.

Sanctuary Services

The Sanctuaries will offer a haven for individuals experiencing mental distress. The CMHC's have close working relationships with local Sanctuary Services, with a regular forum for joint working and clinical discussions.

The Sanctuaries aims are to provide sanctuary and support to individuals at risk of deteriorating mental health, through the provision of a range of supportive interventions in a welcoming and homely environment. This provides an alternative venue to receive early access help and avoids dependence on core mental health services.

The CMHC will work in conjunction with the Sanctuary Services and provide open access to Peer Support Workers. Signposting and referrals will be made to other third sector organisations and agencies as appropriate.

Currently there are three Sanctuaries available.

Sanctuary	Opening Hours
Adferiad Y Noddfa Carmarthen	Thursday, Friday, Saturday & Sunday 5pm- 2am
Pembrokeshire Mind 2 Perrots Road Haverfordwest SA61 2HD	Thursday, Friday, Saturday & Sunday 5pm-2am
Ceredigion Sanctuary 9 Portland Road, Aberystwyth Ceredigion SY23 2NL	Thursday, Friday, Saturday & Sunday 5pm- 2am

Third Sector Organisations

Third Sector organisations have a crucial role in supporting and sustaining individuals and families/carers mental and physical health recovery. There are a wide range of services and activities provided by such organisations across West Wales and it is important that teams ensure they keep up to date with such services and refer into these services as appropriate.

These services and activities are available for all age groups and in different areas of West Wales. In some cases, these organisations are best placed to provide the care and support, with help from Community Mental Health Centres or Teams. The added value of the services provided by the Third Sector to improve mental health and well-being services, supporting the most difficult to reach

communities has been demonstrated repeatedly. CMHT staff will undertake a pivotal role in respect of monitoring arrangements within the Health Board's commissioned third sector services.

Information on these services can be found via the West Wales Action for Mental Health (WWAMH) Directories on: www.wwamh.org.uk and via DEWIS www.dewis.wales and Info Engine https://en.infoengine.cymru.

The Mental Health Services provided by Hywel Dda must work in partnership with these organisations and where organisations are providing significant mental health care they should be included in Care and Treatment Plans (CTP), attend CTP reviews and other aspects of Care Coordination where indicated.

There is a reciprocal collaborating relationship between these organisations and Hywel Dda UHB services to provide quality care and support for people with mental health needs and their families. There should be information sharing between these organisations in order to provide this care and to ensure risk management and positive risk taking to support recovery.

Teams will maintain close working links with other services to promote continuity and consistency of care which can be provided to individuals and carers who use the service. This will include (and not be limited to) strong and effective links with:

- Community Mental Health Teams
- Mental Health Inpatient Units
- Substance Misuse Services-CDAT and DDAS
- General Hospital Teams, including Accident and Emergency (A&E) / Minor Injuries Unit (MIU) and Acute Medical Admissions Unit (AMAU) /Clinical Decisions Unit (CDU)
- Specialist Child and Adolescent Mental Health Services (SCAMHS)
- Older Adult Mental Health Services
- Community Team for Learning Disabilities
- Local Primary Mental Health Services and Integrated Psychological Therapies Service
- Police
- Forensic Mental Health Team
- Welsh Ambulance Service Trust
- Dyfed Powys Police Vulnerability Hub
- Integrated Autism Service and Attention Deficit Hyperactivity Disorder Assessment Service
- Locality Authority
- Local Third Sector Providers
- Mental Health and Learning Disability Liaison Services
- Mental Health Single Point of Contact via 111, option 2
- Duty Clinical Co-ordinator
- Working in line with statutory processes e.g., MAPPA, Safeguarding

Effective links will be maintained through:

- Twice daily directorate bed conference
- Attendance at regular Inpatient 'Ward Rounds' or MDT reviews
- Attendance at Community Managers Forum and Ward Managers Forum
- Attendance at Community Mental Health Team meetings

GP Link Working

Each CMHC will identify individuals to link work with GP practices in their area. Every GP practice must have a Link Worker in mental health. The key purpose of Link Working is to provide support, education and problem-solving for the primary health care team. This entails advising GPs with assessments and management of common mental health problems and acting as a signpost for patients to other services which may benefit them. They ensure people access the best route into a service.

Training and Education

Induction will last 6 months (26 weeks) and will consist of both Corporate and Local Inductions. There is a variety of training and information available on the Workforce Development SharePoint page, “Welcome to Hywel Dda” People Development (*opens in new window*). These provide a broader understanding of the Health Board, its departments, functions, and increase awareness of patient and staff needs and provides a holistic programme.

To meet statutory and best practice requirements, all Practitioners will be expected to be suitably skilled in a range of areas relating to the delivery of community mental health care including record keeping, risk management and therapeutic interventions. A training and skills framework **(Appendix 14)** has been developed as a guidance reference tool for all Practitioners and their Managers to be able to identify opportunities for continuing professional development. It is expected that Community Mental Health Teams will be made up of a group of Practitioners from a range of disciplines with a wide spectrum of skills which are in addition to their core team competencies. A culture of learning, development and improvement will be embedded in each team through leadership, education, and supervision.

- Core Mandatory Training as required by Hywel Dda University Health Board.
- WARRN - Wales Applied Risk Research Network Training.
- STORM — Skills Based Training of Risk Management for suicide prevention and self-harm.
- Co-occurring Mental Health and Substance Framework Misuse Training.
- Psychological Mindfulness Training.
- Recovery workshops.
- Family Psychoeducation Programme (F-PEPPS).

Supervision

Clinical supervision will be in accordance with the Health Board supervision policy relevant to each profession. Formal management supervision will take place at agreed intervals with regular Performance Appraisal Development Reviews (PADRs). In addition to this standard process, staff will use shift handover periods as a learning and development opportunity and for support. Staff will be expected to make their own arrangements for clinical supervision as per the Health Board Policy. Teams are encouraged to also include regular group supervision and formulation meetings with other relevant professionals such as psychologists. The NMC professional Code of Conduct will underpin the supervision to ensure that relationships between service users and staff are conducted within appropriate professional boundaries.

Record Keeping

The record keeping policies relevant to each profession to be read by staff understood and adhered to. This includes medical staff. All patient records are administered via the electronic Care Partner system.

Staff are reminded to not use abbreviations or acronyms in the patient's clinical record. Any paper records such as GP referrals must be scanned into the patient's electronic record.

All entries on Care Partner by Health Care Support Workers must be countersigned in line with the Health Boards 195 Clinical Record Keeping Policy (*opens in new window*) to ensure high quality entries.

Staff are to be reminded that demographic information is a standard requirement especially next of kin details and these must be recorded into the electronic record on WPAS (Welsh Patient Administration System). Where there is no next of kin this must be clearly stated in the record.

Safeguarding

In line with 868- All Wales Safeguarding Procedure staff have a statutory duty to report if they suspect an adult is at risk of abuse or neglect to the safeguarding team. To assist with this decision-making process, staff have access to a Safeguarding Process Map for decision making and reporting. This will prompt staff on the appropriate action to take to report any concerns raised.

There is a Welsh Government requirement that the details of any children the service user has responsibility for are recorded in the service user's electronic record.

It is anticipated that safeguarding concerns will be raised with a qualified member of staff, who will be responsible for overseeing the submission of the safeguarding report and be able to give consideration to relevant clinical information which will inform the detail of the safeguarding report. There may be an exceptional circumstance where the risk to a child or 'adult at risk' is such, that a safeguarding report needs to be made urgently and before an unqualified member of the team has an opportunity to discuss the safeguarding report with a registered practitioner.

The professional should then risk assess the situation and using clinical judgement decide on the best way to inform the service user / patient of the referral. The relaying of information would normally be completed on a face-to-face basis with the exception being, the use of a telephone call to relay the news. This would be made based on the current risk or the possibility of increasing risk to the person, the child or the professional. Furthermore, if the risks have increased and staff are unable to inform the service user on a face-to-face basis and a telephone contact is the only option available to fulfil the criteria for the referral, then the qualified professional should inform the Senior Nurse / Service manager of the situation and offer rationale for their decision making.

This should also be documented fully on the electronic record keeping system (Care partner) with clear rationale for decision making, discussions and the outcome. A follow up meeting should/could be arranged with the individual to provide further support if the information is given via telephone.

Safety of Staff

Professionals working in the area of mental health crisis in the community need to have a number of safeguards in place in order to minimise the risks to themselves and others in all circumstances. This process begins with good preparation for the role, a rigorous triage system, and a set of procedures within the team, especially around lone-working and the development of a culture within the team of safety first and support for colleagues. Some features of this are set out below:

- Staff will be equipped with mobile phones when working in the community.
- A copy of the log of visits is left at base so that incoming teams are aware of others' whereabouts.
- The management on call system provides support to services delivered outside of scheduled hours of operation, where indicated.
- All new assessments will be carried out In line with the Health Board's 170- Lone Worker Policy (*opens in new window*).
- All service user contact will be organised to take account of the clinical risks identified within the risk assessment and management plan.

Quality Assurance

Audit reviews of documentation will be undertaken by team leaders and results will be fed back to relevant practitioners with actions if needed. Supervision is key to improving staff skills knowledge and confidence as well as helping manage staff wellbeing. The Service Manager should review a sample of supervision records during 1-1 meetings with team leaders.

All staff are to know where to access this service specification. CMHC team leaders are to ensure that all staff have read and understand the service specification and that care to service users is being delivered accordingly, this will be evidenced though a signatory sheet which will be retained with the service specification by the Team Leader.

All members of staff will be knowledgeable regarding the requirements of 'Putting things Right' Guidance Wales, this will be evidenced through the PADR process as a core objective for all staff.

All members of staff will be knowledgeable regarding the process following a Serious Incident, and their responsibilities, this will be evidenced through the PADR process as a core objective for all staff.

Evidenced-based best practice guidance - National Institute for Health Care Excellence

NICE provide evidence-based recommendations developed by independent committees, including professionals and lay members, and consulted on by stakeholders on mental health presentations.

Staff should consult and incorporate evidence-based practice into their role and interventions as Mental Health Practitioners.

Common mental health problems: identification and pathways to care

Self-harm: assessment, management and preventing recurrence

Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services

Guidance and standards 'Adult Community mental health Services in Wales' NHS Wales collaborative

Bipolar disorder: assessment and management | Guidance | NICE

Anxiety disorders | Quality standards | NICE

Generalised anxiety disorder and panic disorder in adults: management | Guidance | NICE

Depression in adults: treatment and management | Guidance | NICE

Preventing suicide in community and custodial settings | Guidance | NICE

Antisocial personality disorder: prevention and management | Guidance | NICE

Borderline personality disorder: recognition and management | Guidance | NICE

Psychosis and schizophrenia in adults: prevention and management | Guidance | NICE

Transition between inpatient mental health settings and community or care home settings

Violence and aggression: short-term management in mental health, health and community settings

Coexisting severe mental illness and substance misuse: community health and social care services

Transition between inpatient mental health settings and community or care home settings

Violent and aggressive behaviours in people with mental health problems

References

Mental Health Act 1983 HMSO. London

The Mental Health Act 1983 Code of Practice for Wales 2016.

Mental Health (Wales) Measure 2010.

Code of Practice to Parts 2 & 3 of the Mental Health (Wales) Measure 2010

Mental Health (Care Coordination and Care and Treatment Planning) (Wales) Regulations 2011

Welsh Government (2005) Policy Implementation Guidance on the development of Crisis Resolution/Home Treatment (CR/HT) services in Wales. Welsh Government. Cardiff

Welsh Government (2016) Mental Health Crisis Care Concordat. Welsh Government. Cardiff

Policing and Crime Act 2017. HMSO, London

Welsh Health Care Standards 2015

NMC Code-Standards for Record Keeping

Appendices

Appendix 1- Telephone Triage Form

Telephone Triage Tool.pdf

Appendix 2- Comprehensive Assessment Tool

Mental Health Services - Compreher

Appendix 3- Welfare Check

Welfare Checks.docx

Appendix 4 - St John Conveyance Protocol

Protocol for the St John Cymru Mental

Appendix 5 - St John Pathway

St John Ambulance Cymru Pathway.docx

Appendix 6 - St John Conveyance Risk Assessment

St John's Mental Health Conveyance Fc

Appendix 7- Gatekeeping Assessment Outcome Form

GATEKEEPING ASSESSMENT OUTCC

Appendix 8- Police and CRHT Pathway

Police and Crisis team flow chart.docx

Appendix 9- Section 136 Flow Chart for Police Officers

Section 136 Flow chart v2.docx

Appendix 10- WARRN Tool

WARRN Tool.docx

Appendix 11 - Inpatient Care Flowchart

CMHT inpatient Care flow chart.pdf

Appendix 12- Safety and Planning Leaflet

leaflet master copy with fold lines.pdf

Appendix 13- Discharge Letters

CTP Discharge letter.doc

welsh gov leaflet for discharges.pdf

Discharge Letter.docx

Appendix 14- Training and Skills Framework

Training and Skills Framework Visualisat